DENTAL HISTORY

The main reason you are here today is:
________________________________________________________________________________

Name and location of previous dentist:
________________________________________________
________________________________

Date of last dental exam: _____________________
Date of last x-rays: _____________________

1. Do your gums bleed when brushing and/or flossing? □ YES □ NO
2. Are your teeth sensitive to hot/cold liquids or foods? □ YES □ NO
3. Are your teeth sensitive to sweet/sour liquids or foods? □ YES □ NO
4. Do you feel pain in any of your teeth? □ YES □ NO
   If yes where? ____________________________
5. Do you have or have you had any sores or lumps in or around your mouth? □ YES □ NO
6. Have you ever had any head, neck, or jaw injuries? □ YES □ NO
7. Does your jaw click or hurt when you open and close? □ YES □ NO
8. Do you have frequent headaches in the morning? □ YES □ NO
9. Do you clench or grind your teeth? □ YES □ NO
10. Do you bite your cheeks or lips frequently? □ YES □ NO
11. Have you ever had any difficult extractions in the past? □ YES □ NO
12. Have you ever had any prolonged bleeding following extractions or dental treatment? □ YES □ NO
13. Have you had any orthodontic treatment? □ YES □ NO
   If yes, when? ____________________________
   If no are you interested? ________________
14. Do you wear dentures or partials? □ YES □ NO
   If yes, year of placement: ________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? □ YES □ NO
16. Do you have dry mouth? □ YES □ NO
17. Do you like your smile? □ YES □ NO
18. Would you be interested in whitening your teeth? □ YES □ NO

Referral Information

Whom may we thank for referring you to our practice?

□ Another Patient, Name: ____________________________ □ Yellow Pages
□ Newspaper □ School (dental health presentation)
□ Work □ Insurance company
□ Dental Office □ Other: ____________________________